Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Triptan Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Amerge, Frova, Imitrex tablets and nasal spray, Maxalt, Maxalt-MLT, Relpax, Zomig nasal spray, and Zomig ZMT. **PA is not needed for Axert or Zomig for quantity requests less than or equal to six units per month or for Imitrex injections for quantity requests less than or equal to two units (four injections) per month.** Additional information about triptans can be found within the MassHealth Drug List at **www.mass.gov/masshealth.**

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m

Member's place of residence ☐ home ☐ nursing facility

Medication information

Triptan request / **Quantity request**

- ☐ Amerge tablet _____
- ☐ Axert tablet _____
- ☐ Frova tablet _____
- ☐ Imitrex injection _____
- ☐ Imitrex nasal spray _____
- ☐ Imitrex tablet _____
- ☐ Maxalt tablet _____
- ☐ Maxalt-MLT tablet _____
- ☐ Relpax tablet _____
- ☐ Zomig nasal spray _____
- ☐ Zomig tablet _____
- ☐ Zomig-ZMT tablet _____
- ☐ Other: _____

Dose, frequency, and duration of requested drug

Drug NDC (if known)

Indication for triptan requested (Check one.)

☐ Acute treatment of migraine

Frequency of migraine attacks (number/month) _____

Is member currently on migraine prophylaxis?

☐ No. Explain why not. _____

☐ Yes. Specify agent(s), dose, and frequency. _____

☐ Other. Specify pertinent medical history, diagnostic studies, and/or laboratory tests.

Please attach supporting documentation (e.g., copies of medical records and/or office notes).

Has member tried the following triptans: Axert and Zomig?

☐ Yes. Complete boxes A and B.

☐ No. Explain why not.

A. Dates of Axert use

Dose and frequency

Did member experience any of the following?

☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

Please attach supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

Is the member under the care of a neurologist?

☐ Yes.

☐ No.

Name of neurologist

Telephone No.

Date of last visit or consult

B. Dates of Zomig use

Dose and frequency

Did member experience any of the following?

☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

Please attach supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

Pharmacy information

Name	Pharmacy provider no. *Optional*	Telephone no. ( )	Fax no. ( ) *Optional*	
Address		City	State	Zip *Optional*

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address *Optional*			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date